

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-004060

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED JAN 19 1962 218

1003

331

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN ST. LOUIS, MO.

Length of stay in 1b

76 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY

OR
TOWN St. Louis

Inside Limits

Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

ST. LOUIS CITY HOSP. # 1

Inside Limits

Yes ☒ No ☐

d. STREET (If outside, give location)

ADDRESS

3708 Keokuk Street

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

GEORGE

KORMANN

4. DATE
OF
DEATH

Month

Day

Year

JAN

8

1962

5. SEX

M

6. COLOR OR RACE

W

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☒

8. DATE OF BIRTH

12/10/1885

76

9. AGE (last birthday)

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (City and state or country)

St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY

U S A

13a. FATHER'S NAME

Eugene Kormann

13b. MOTHER'S MAIDEN NAME

Ida Wilker

14. NAME OF HUSBAND OR WIFE

Odemae

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Wm. Fluhrer 3712 Keokuk Street

18. CAUSE OF DEATH (Enter only one cause per line for
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

BACTERIAL SHOCK

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

RUPTURED URTERA

DUE TO (c)

609x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)

ACUTE BRONCHITIS

PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11/24/61

to 1/8/62

and last saw her alive on 1/8/62

Death occurred at 1:20

a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE

1/11/62

23c. NAME OF CEMETERY OR CREMATORY

Concordia Cemetery

23d. LOCATION (City, town, or county)

St. Louis, Missouri

24. FUNERAL DIRECTOR

ADDRESS

Beiderwieden F.H.Inc. 1936 St.Louis Ave

25. DATE RECD. BY LOCAL REG.

JAN 9 1962

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
 or by _____, Student Embalmer No. _____
 working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed *Donald E. [Signature]*

Licensed Embalmer No. 4520

P. O. Address *A. L. [Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.